Inmate Death - Clinical Care Review

723.1 PURPOSE AND SCOPE

The purpose of this policy is to establish the actions and notifications required in the event of an in-custody death and the medical care received by the inmate. The policy requires that a review of all in-custody deaths be conducted to assess the appropriateness of the clinical care provided and the effectiveness of the facility's policies and procedures.

723.1.1 DEFINITIONS

Definitions related to this policy include:

Administrative review - An assessment of the facility's emergency response actions surrounding the death of an inmate. The purpose of the administrative review is to identify areas where operations, policies and procedures may be improved.

Clinical mortality review (CMR) - An assessment of the medical condition of the inmate prior to treatment, the clinical care provided by contractors and the circumstances of the death. The purpose of the CMR is to identify areas of patient care or system policies and procedures that may be improved.

Psychological autopsy - A written reconstruction of an inmate's life with an emphasis on factors that may have contributed to his/her death. This is sometimes referred to as a psychological reconstruction and is usually conducted by a psychologist or other qualified mental health care professional.

723.2 POLICY

It is the policy of this office that all in-custody deaths are reviewed to determine the appropriateness of the clinical care provided, to determine whether existing policies are appropriate or if revision is necessary and to identify any other issues associated with the circumstances of the death. A postmortem examination should be performed according to the laws of the jurisdiction if the cause of death is unknown, if the death occurred under suspicious circumstances or if the inmate was not under current medical care.

723.3 NOTIFICATIONS

In the event of an in-custody death, all authorities with jurisdiction, including the Coroner or the authorized designee shall immediately be notified by the Chief Deputy of Corrections or the authorized designee at the time of death. All in custody deaths require notification to the SSB supervisor as soon as possible to determine who will conduct the death investigation. Staff will secure the area where the death occurred and obtain names of witnesses to the death.

The contract medical provider should also be notified and should coordinate with the Chief Deputy of Corrections, who will be responsible for notifying his/her chain of command regarding all medical issues surrounding the in-custody death.

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Information regarding the individual designated by the deceased inmate for notification should be provided to the Coroner or the authorized designee, who is charged with the responsibility of making such notifications.

723.4 DOCUMENTATION

The qualified health care professional on duty at the time of the in-custody death shall ensure that all witnessed facts concerning the death are documented on the inmate's health record. Written documentation should include, but is not limited to, the time of death, the preceding circumstances surrounding the death, nature of the death, treatment rendered, and who was notified of the death and by whom.

The contract medical provider should initiate a death report and document it in accordance with the Continuous Quality Improvement Policy.

723.5 CLOSING THE MEDICAL RECORD

The healthcare professional should review the inmate's health record to ensure appropriate entries have been made, and within 24 hours of the death have the original and a complete copy of the medical record made and delivered as follows (see the Reporting Inmate Deaths Policy):

(a) Seal the original in an envelope and retain it in the custody of the contract medical provider.

(b) Send the copy to the facility for inclusion into the inmate file and retain it in accordance with established records retention schedules.

723.6 DEATH BY SUICIDE

In the event of suspected inmate suicide, the qualified health care professional shall make a report within 24 hours to the contract medical provider containing:

(a) The inmate's known mental health history.

(b) The most recent known mental health treatment.

(c) All known circumstances surrounding the suicide.

A psychological autopsy should be conducted by a qualified mental health care professional if the cause of death is determined to be suicide.

The initial CMR should be conducted by a healthcare professional and, if available, mental health care professional. The CMR should be finalized within 30 days by the contract medical provider. The findings should be shared with the treating staff.

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723.7 DEATH REVIEW

All deaths should be reviewed within 30 days. The review shall consist of an administrative review, a CMR and a psychological autopsy if the death was by suicide.

Treating staff shall be informed of the CMR and the administrative review findings at the quarterly continuous quality improvement meeting.

Corrective actions identified through the CMR should be implemented and monitored in accordance with the Continuous Quality Improvement Policy for systemic issues and the Inmate Safety Program Policy for staff-related issues.

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